

The Task Force on Regulatory Efficiency: Interim Report

Maryland Department of Health and Mental Hygiene

July 27, 2011

Table of Contents

EXECUTIVE SUMMARY	i
INTRODUCTION	1
SECTION A: Long Term Care (Nursing Homes)	2
Resident Care.....	2
Resident Movement.....	4
Technology	7
Resident Choice and Independence	7
SECTION B: Assisted Living.....	9
Staff Certification	9
Resident Care.....	10
Emergency Preparedness	11
SECTION C: Adult Medical Day Care Facilities.....	12
Quality Assurance.....	12
Reporting Requirements	13
Staffing	14
SECTION D: Mental Health.....	15
Therapeutic Group Homes.....	16
Community Mental Health Programs	23
Mobile Treatment Services.....	26
Outpatient Mental Health Clinics	27
Psychiatric Rehabilitation Programs.....	28
SECTION E: Developmental Disabilities	30
Licensing and Services Delivery	30
Record Retention	32
SECTION F: Substance Abuse Treatment Programs	33
APPENDIX A: List of Regulatory Proposals and Draft Response.....	36
APPENDIX B: List of Questions Requiring Further Information	40
APPENDIX C: Form for Additional Public Comment.....	43

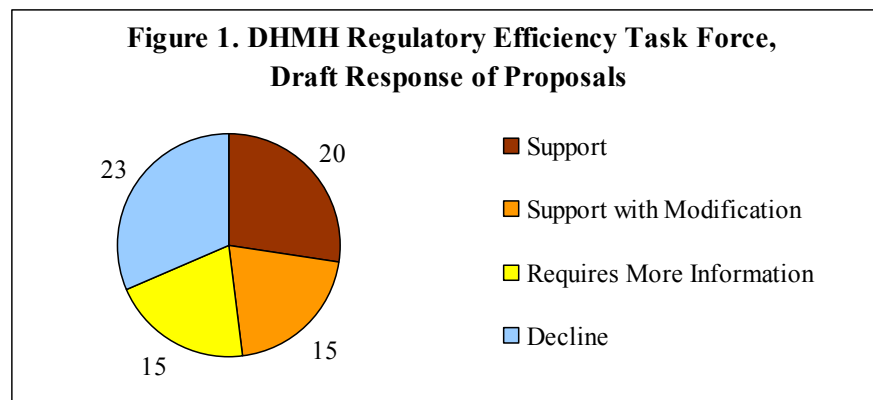
EXECUTIVE SUMMARY

In April 2011, the Department of Health and Mental Hygiene launched an effort to identify regulatory improvements and make service to Maryland residents more efficient and effective.

Following a public comment period, the Department's Task Force on Regulatory Efficiency is issuing its first report.

The report finds many areas for improvement across regulation of skilled nursing facilities, assisted living homes, community mental health programs, programs serving individuals with developmental disabilities, and substance abuse treatment programs.

The Task Force reviewed 73 proposals from the public for regulatory change. The Task Force's draft response is to support 20 of the proposals (27%), support with modification 15 of the proposals (20.5%), seek additional information on 15 of the proposals (20.5%), and decline 23 of the proposals (31.5%). (Figure 1).



Ideas with a draft review in favor of adoption include:

- **Allowing wireless call bell systems, instead of hard wired systems, in skilled nursing facilities.** This will allow modern systems to be implemented to benefit facility residents, while reducing costs for the facilities themselves.
- **Permitting clinicians in skilled nursing facilities to use electronic signatures rather than hand-written signatures for progress notes and medication orders.** This will clarify that modern, efficient electronic medical record systems are encouraged in skilled nursing facilities.
- **Allowing opposite-sex siblings to share the same room in a skilled nursing facility.** Current nursing home regulations require residents sharing a room to be the same gender, unless husband and wife.
- **Adding the Term “Program Administrator” in regulations governing community mental health programs.** This will provide additional flexibility and efficiency for program management.

Ideas with a draft review in favor of adoption with modifications include:

- **Altering requirements that skilled nursing facilities notify the state about individuals with conjunctivitis and other conditions.** Current regulations may be overly prescriptive with respect to conditions that do not require this level of surveillance or precaution.
- **Changing how often methadone plans must be updated for individuals in substance abuse treatment.** For certain stable patients, a review every six months instead of every three months may suffice.
- **Altering requirements about covers on hot water bottles and ice caps.** Certain new technologies may not require covers for hot water bottles and ice caps.

The Task Force is requesting additional comment on 15 proposals through specific questions including:

- **Should psychiatric nurse practitioners take on additional duties?** Public comment suggested allowing psychiatric nurse practitioners to take on the same responsibilities as psychiatrists in the oversight of community mental health programs.
- **Should regulations for programs that serve adults with developmental disabilities be distinguished from those for programs that serve children with developmental disabilities?** Public comment suggested distinguishing these regulations could avoid confusion in the applicability of certain regulations.
- **Should medical day care centers have a medical director?** Public comment suggested that since patients have their own doctor, facility medical directors may not be necessary.

Some ideas received an unfavorable draft review by the Task Force. For example, the Task Force:

- **Declines to eliminate the requirement that therapeutic group homes collaborate with the child's primary care physician.** The child's primary care provider may have information and input on health that is critically important to the well-being of the child.
- **Declines to make the role of the Director of Nursing in a skilled nursing facility optional.** This role is critical to protection of patients, and the Director of Nursing is permitted to delegate certain functions to others.
- **Declines to reduce from weekly to monthly the required resident care note in assisted living facilities.** Weekly care notes are the appropriate minimal requirement in the assisted living environment, where observations by direct care staff regarding a

resident's status and any change of condition are relied on by clinicians who may only make periodic visits.

The next step in this process is a period of public comment on the Task Force's draft responses and requests for additional information.

In the fall, the Department intends to make final decisions on which proposals to implement. Proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

INTRODUCTION

In April 2011, the Department launched the Task Force on Regulatory Efficiency, to conduct a cross-agency review of DHMH facility regulations to promote greater efficiency and effectiveness.

The Task Force is co-chaired by Wendy A. Kronmiller, Assistant Secretary for Regulatory Affairs at DHMH, and Mark Luckner, Executive Director, Community Health Resources Commission.

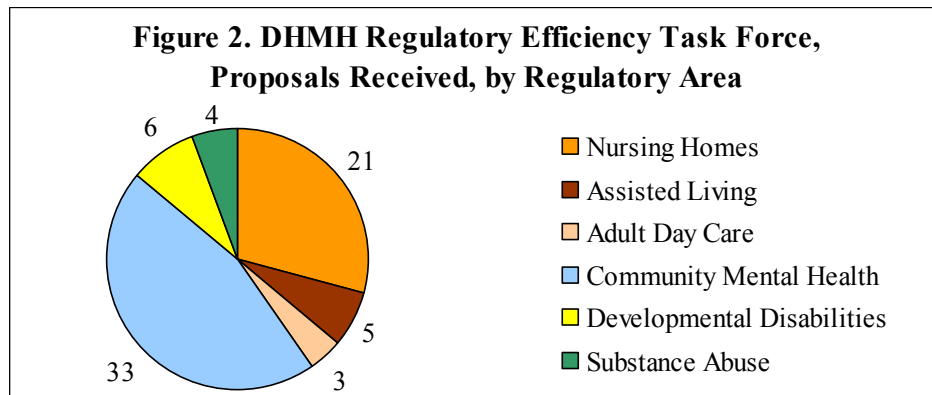
Six operating divisions of DHMH serve on the Task Force. DHMH consulted with three additional State agencies in preparing draft responses.

Twelve individuals and organizations submitted proposals for Task Force review. The following is an overview of the types of regulatory proposals submitted by the public. (Figure 2).

The analysis and response by the Task Force is in draft form, and the Task Force is now soliciting additional public comment on these draft responses. Proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment,

before taking effect. The Department will draft regulatory changes and publish them in the Maryland Register after

the second public comment period has closed and the final report has been issued.



The public may comment on any of the draft responses to the numbered proposals or to any of the lettered questions (Appendix B). The Task Force has created a form to guide the process of submitting additional public comment (Appendix C). The comment period on these draft findings and questions will close on August 26, 2011. The final report, to follow the second/final public comment period, will be issued later this fall. If appropriate, we will include in the final report legislative recommendations for consideration during the 2012 session.

SECTION A: Long Term Care (Nursing Homes)

There are an estimated 25,240 individuals who reside in approximately 230 skilled nursing facilities in Maryland. Nursing homes are regulated by both the federal government, Center for Medicare and Medicaid Services, and state government, DHMH's Office of Health Care Quality. The goal of these regulations is to protect the safety of residents, to promote their overall health and well-being, and to ensure that consumers who require nursing home services receive the health care that they need.

The Office of Health Care Quality's Long-Term Care Unit conducts a variety of activities, including unannounced on-site surveys, follow-up visits, and complaint investigations, to ensure that nursing homes meet and maintain state licensure and federal Medicare/Medicaid standards. Enforcement actions are taken, when appropriate, to ensure compliance with State and federal regulations. The Office of Health Care Quality also investigates complaints of resident abuse by staff and assists with criminal and civil prosecution of staff members who abuse vulnerable adults. The Ombudsman, located within the Department of Aging, in coordination with local jurisdictions also plays an important role in promoting the rights and safety of nursing home residents.

Nursing facility regulations are comprehensive and detailed, to protect vulnerable residents, promote care, and ensure facility and medical compliance with basic standards. The Task Force received a total of 21 proposals from the public in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

Resident Care

- ***Proposal #1: Update Maryland's regulatory definitions to reflect the national implementation of new person-centered standard care assessments (COMAR 10.07.02.01B).***

The federal government is implementing standardized assessments to facilitate person-centered assessment, in its Minimum Data Set 3.0 (MDS 3.0), which is a national, comprehensive effort to implement standard, person-centered assessments that will facilitate enhanced care management in nursing homes. Public comment suggested that Maryland's regulatory definitions reflect these new national standards.

DRAFT RESPONSE: The Task Force supports this proposal.

- ***Proposal #2: Allow resident discretion regarding the notification of family members in care planning conferences (COMAR 10.07.02.37).***

Regulations require that an “interdisciplinary team” complete a resident-specific care plan for each resident within 7 calendar days following completion of all assessments, and this care plan should be updated at least quarterly and/or when a significant change in the resident occurs. The regulations also require the facility to give a family member or resident’s representative 7 calendar days notice, in writing, of the location, date, and time of the care planning conference. Public comment suggested that notification requirements for the family member or resident’s representative only apply, “if the resident consents,” or if the resident lacks capacity to consent to health care decisions, arguing this would promote patient choice.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #3: *Clarify the role of Director of Nursing (COMAR 10.07.02.12G).***

The Director of Nursing plays an important role in the delivery of resident care in nursing facilities, and regulations spell out a number of specific duties that the Director of Nursing *shall* conduct, including defining the type of nursing care provided by the facility, preparing written job descriptions for nursing personnel, and planning for the total nursing needs of residents. Public comment suggested that these duties should not be requirements, but more of a guideline, suggesting that the term “shall” should become “may.”

DRAFT RESPONSE: The Task Force declines this proposal. The role of the Director of Nursing is a pivotal role at a nursing facility, and his/her duties need to be clearly spelled out in regulation. In addition, regulations also allow the Director of Nursing to delegate certain duties, where appropriate.

- **Proposal #4: *Clarification that facilities may use “Leave of Absence Policies” for medications (COMAR 10.07.02.15).***

Current regulations prohibit nurses from packaging, re-packaging, or labeling any medications in nursing facilities. The Department has permitted nurses to provide medications to families under a facility “Leave of Absence” policies and procedures (COMAR 10.07.02.15G). A “Leave of Absence” is a period of 24 hours or fewer. Public comment suggested that the restriction on nurse re-packaging and labeling refer to the “Leave of Absence” policy.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #5: *Return of unused medications (COMAR 10.07.02.15C (1) (o)).***

Current regulations provide that all medications written on prescriptions for residents who have left the nursing home shall be destroyed. Public comment proposed that this regulation be changed to permit unused medications to be returned, consistent with regulations of the Board of Pharmacy.

DRAFT RESPONSE: The Task Force supports this proposal.

Resident Movement

- **Proposal #6:** *Enable nursing homes to increase bed capacity in times of an emergency without getting prior approval from the Department (COMAR 10.07.02.03-1).*

Current regulations indicate that nursing homes may only exceed licensed bed capacity if requested to do so by the Department, or if the Department approves a request from the facility, typically when emergency situations exist. Under these circumstances, nursing homes are required to submit a written request to the Department, which must be approved by DHMH, prior to the facility increasing bed capacity. The public comment suggested that nursing homes should be able to increase bed capacity during times of an emergency *without* getting prior approval from the Department and that this increase should not be limited to a 30-day period, as is currently required.

DRAFT RESPONSE: The Task Force declines this proposal. The Office of Health Care Quality now has an emergency response team available 24/7 to address these requests. The Department and Maryland Institute for Emergency Medical Services Systems must be able to maintain information about facilities exceeding bed capacity to provide a complete picture of the impact of an emergency situation, and so that the Department can monitor conditions when a facility exceeds capacity.

- **Proposal #7:** *Reduce notification requirements for admission of patients with communicable diseases (COMAR 10.07.02.08G).*

Current regulations prohibit a facility from denying admissions or involuntarily discharging a resident solely because the patient has a communicable disease. The regulations further stipulate that the facility must notify the Department of its intention to admit a resident with a communicable disease, before admission. The Secretary of the Department may prohibit the admission of a patient with a communicable disease if it is determined that admission would pose a risk to the health, safety, or welfare of other residents. Public comment suggested that the requirement for prior notification and approval by DHMH should be waived, with the rationale that universal precautions and the requirement for infection control policies should be sufficient for facilities to admit patients with communicable diseases.

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Task Force agrees that the list of communicable diseases, which currently includes HIV and conjunctivitis, should be reviewed and updated, to be consistent with current practices and standards.

- **Proposal #8:** *Combine patient transport and resident relocation policies into a single regulation (COMAR 10.07.02.23).*

Regulations require nursing homes to have written transfer agreements in place with at least one acute hospital to ensure resident continuity of care and notification of the patient's family in the event of patient transport to the hospital. Public comment suggested that another regulation, which requires a Resident Relocation Plan, is redundant because of the

requirement of a transfer agreement governing when a resident must be transported to the hospital.

DRAFT RESPONSE: The Task Force declines this proposal. The transfer agreement referenced in .23 relates to an individual resident's transport to a hospital in the event his or her care needs can no longer be met at a nursing home. The purpose of a Resident Relocation Plan is to relocate multiple residents in the event of an emergency situation. The two requirements serve different purposes. The Task Force is seeking additional public input on the following question:

Question a. What amendments, if any, should be made to regulations governing resident transport and relocation to make the requirements more efficient and effective, while preserving resident security and safety?

- **Proposal #9: *Waive DHMH approval for construction of new nursing facilities (COMAR 10.07.02.25).***

Current regulations require that the sites of new nursing facilities must be approved by the Department, and the regulations set forth a number of criteria that new facilities must meet, including noise control, maintenance of roads in passable conditions, and an analysis of projected new traffic patterns. Public comment suggested that these regulations, and prior approval by the Department, are obsolete or unnecessary, in light of certificate of need requirements and local/state zoning laws.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #10: *Simplify requirements for emergency power generation (COMAR 10.07.02.26F(5)(c)).***

Nursing home regulations require the facilities to have at least 48 hours worth of emergency power from fuel stored on-site. Public comment suggested that the requirement "from fuel stored on-site" be removed.

DRAFT RESPONSE: The Task Force declines this proposal. The requirement that fuel be available on-site is an essential requirement; if there is a widespread emergency there is likely to be limited access to fuel, and residents' health will be at risk.

- **Proposal #11: *Modify requirements regarding the distance between beds (COMAR 10.07.02.28C(1)).***

Regulations require that nursing homes provide at least 3 feet between beds and at least 18 inches from walls and heating units. Public comment suggested that the term 'walls' be removed from the regulation, and suggested alternative language: "A distance of at least 3 feet shall be maintained between each bed. Each bed is to be placed so that all sides of the bed are at least 18 inches from heating units."

DRAFT RESPONSE: The Task Force is seeking public input on the following questions:

Question b. What, if any, barriers or practical difficulties might prevent a resident's bed from being placed against a wall?

Question c. To the extent there are barriers or practical difficulties, do these exist for all residents or for residents with certain health care or mobility needs?

- **Proposal #12:** *Simplify requirements for hot water bottles and ice caps (COMAR 10.07.02.29B).*

Regulations require that covers be placed on all hot water bottles and ice caps before they are placed in a bed or on a patient, and that water temperatures not exceed 120°. Public comment suggested that these requirements be waived, or amended to reflect the use of hot packs and ice packs which are contained and reach a specific temperature.

DRAFT RESPONSE: The Task Force supports this proposal with modification. Current regulations should be updated to anticipate new technology and be maintained for traditional hot water bottles and ice caps.

- **Proposal #13:** *Provide more flexibility for dayroom and dining area (COMAR 10.07.02.31).*

Nursing regulations require the facility to provide at least one or more attractively furnished areas of adequate size for resident dining, occupational therapy, and social activities. These regulations require the dining area to be at least 12 square feet per ambulatory resident and the multi-purpose room to be no less than 30 square feet per bed. Public comment suggested that these specific square footage requirements be removed.

DRAFT RESPONSE: The Task Force declines this proposal. Maintaining physical standards for the dayroom and dining area is important for overall resident experience and quality of life.

- **Proposal #14:** *Changes to existing kitchens and dietetic service areas (COMAR 10.07.02.32(F)(2)).*

Current regulations require nursing homes, when making changes to existing kitchens and constructing new food service departments, to seek a waiver granting approval for these adjustments. For example, there are specific minimum space requirements. Public comment suggested that the regulations be amended such that the facility can be determined compliant, without having to seek a waiver.

DRAFT RESPONSE: The Task Force declines this proposal. The Task Force is seeking public input on the following question:

Question d: What, if any, specific requirements as to kitchens and food services should be subject to change by a facility during renovation without the Department's prior approval?

Technology

- **Proposal #15: *Utilize electronic medical record systems and electronic signatures (COMAR 10.07.02.10C(4) and H (2))***

Current regulations require the attending physician or licensed or certified professional health care practitioner in nursing homes to determine the progress of each resident's condition and, at each visit, provide a legible progress note in a timely manner for placement in the resident's medical chart. In addition, current regulations requiring attending physicians to provide timely medical orders based on an appropriate resident assessment and to provide "sufficiently clear, legible, written medication orders to avoid misinterpretation and potential errors." Public comment suggested that these regulations be amended to reflect the use of electronic medical record systems and use of electronic signatures.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #16: *Utilize electronic patient health records (COMAR 10.07.02.20).***

Current regulations require nursing homes to maintain records for all patients, including a summary sheet showing the patient's name, social security number, citizenship, marital status and other personal characteristics; the names and addresses of personal physicians, dentist, parents' names or next of kin; documented evidence of the assessment of the needs of the patient; authentication of hospital diagnoses or discharge summaries; consultation reports; observations and progress notes; and the interdisciplinary care plan. Public comment suggested that these regulations be amended to reference the use of electronic patient health records.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #17: *Reflect use of wireless call bell systems (COMAR 10.07.02.27)***

Public comment suggested that regulations should permit the use of wireless call bell systems that are pager activated; it was further suggested that current language mandating a detachable extension cord to each patient's bed be amended to reflect wireless systems.

DRAFT RESPONSE: The Task Force supports this proposal.

Resident Choice and Independence

- **Proposal #18: *Facilitate resident self-administration of medications (COMAR 10.07.02.27).***

Public comment suggested that regulations should be updated to invite some patients, where appropriate, to administer their own medications, as a way to facilitate a more 'home-like' environment.

DRAFT RESPONSE: The Task Force supports this proposal with modification. Residents currently have rights to administer their own medications, if they are capable of doing so, under the Resident’s Bill of Rights. The Department will clarify regulations to make it clear that most medications may be safely stored and accessible in the room of a patient who self-medicates.

- **Proposal #19: *Enable opposite-sex siblings to share the same room* (COMAR 10.07.02.28).**

Current nursing home regulations require residents sharing a room to be the same sex, unless husband and wife. Public comment suggested that two opposite-gender siblings should be permitted to share the same room.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #20: *Permit residents to bring their own personal furnishings to the nursing home* (COMAR 10.07.02.28D).**

Current regulations list the responsibilities of nursing homes in terms of the types of furnishings that must be provided for residents. Public comment suggested that regulations should enable or clarify that residents are permitted to bring their own furnishings.

DRAFT RESPONSE: The Task Force requests additional public input on the following question:

Question e. Are there reasonable limitations or requirements in permitting residents to bring in their own furnishings?

- **Proposal #21: *Accommodate various dining styles* (COMAR 10.07.02.13).**

The dietetic services provided at nursing facilities provide for standards in terms of frequency, nutritional value, and preparation. Public comment suggested that these regulations could be updated to accommodate variety in dining styles and preferences as well as person-centered care in terms of frequency, quality, and timing of meals.

DRAFT RESPONSE: The Task Force supports this proposal. In addition, the Task Force requests additional public input on the following questions:

Question f. How should the Department review such requirements as frequency of meals, posting of menus, to better reflect current standards of person-centered care?

Question g. Which specific standards in COMAR 10.07.02.13((G) and (H) are appropriate for change?

SECTION B: Assisted Living

Assisted living facilities are “home-like” settings that provide housing and supportive services, supervision, personalized assistance, and/or health-related services to meet the needs of residents who are unable to perform or need assistance in performing activities of daily living. Assisted living is a way to provide care to individuals who are having difficulty living independently, but do not need the level of nursing services provided in a nursing home. Assisted living providers furnish a place to live, meals, and assistance with daily activities, such as dressing, bathing, eating, and managing medications.

Assisted living facilities have four defined levels of care, reflecting the different health care needs of individuals, which help to determine the variety of different services and care provided on site, such as physical or occupational therapy, transportation, and hospice services. Individuals who live in assisted living facilities generally have less complicated medical problems than residents of nursing homes.

There are approximately 1,375 licensed assisted living providers in Maryland, which have the capacity to serve almost 20,000 residents. Since 2002, the capacity of assisted living facilities has grown significantly in Maryland. These facilities range from large, corporate-managed facilities where hundreds of people live in their own apartments to small, private homes in which owners provide services to residents who may share a bedroom. The majority of Maryland’s assisted living facilities are small sites, with the ability to serve fewer than ten individuals.

Assisted living programs are regulated by the Office of Health Care Quality to promote the safety and well-being of the individuals receiving services and to ensure that these programs meet and maintain state licensure standards. Regulations are enforced through unannounced on-site surveys, follow-up visits, and complaint investigations to ensure that these programs meet and maintain state licensure and federal Medicare/Medicaid standards.

The Task Force received five proposals in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

Staff Certification

- **Proposal #22: Adjust first aid training requirements (COMAR 10.07.14.19).**

Current regulations provide for basic qualifications for employees of assisted living facilities to ensure the quality of care of individuals receiving services in the program. These basic qualifications include that the employee must be at least 18 years of age or older (unless this

requirement is waived by the Department for good cause); be free from communicable diseases such as tuberculosis, measles, or mumps; and be without any impairments that would hinder the employee's performance.

In addition, regulations require that employees receive "initial and annual training" in basic first aid by a certified training instructor. Public comment suggested that first aid training is analogous to CPR training, which is often a multi-year certification, not annual. Public comment proposed that regulations be amended to make first aid training be required "on an initial ongoing basis" similar to CPR.

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Department will require first aid training at least every two years.

- **Proposal #23:** *Waive requirement that employees submit a physician's statement that an employee is free from certain "impairment."* (COMAR 10.07.14.19).

Current regulations require that employees must be examined by a physician, and "as evidenced by a physician's statement... [do not have] any impairment that would hinder the performance of assigned responsibilities." Public comment contends that to satisfy this requirement, the employee must undergo a complete physical, and public comment suggested that this requirement is costly to both the employee and provider, and should be removed.

DRAFT RESPONSE: The Task Force supports this proposal.

Resident Care

- **Proposal #24:** *Update service plan requirements to reflect Nurse Practice Act* (COMAR 10.07.14.26B).

Current regulations require that assisted living facilities develop a service plan for each resident to ensure that all services are provided in a manner that respects and enhance the dignity, privacy, resident choice, and independence. The regulations require that each resident be assessed using the "Resident Assessment Tool" within 48 hours of entering the facility, and/or when a significant change of conditions occurs, or with each "nonroutine hospitalization." Public comment suggested that the use of the Resident Assessment Tool has been proven to be problematic, time-consuming, and costly, and suggested that this Resident Assessment Tool requirement be changed such that assisted living facilities are required to use a nursing assessment, in accordance with the Nurse Practice Act (COMAR 10.27.09.02). In addition, public comment suggested that regulations be clarified to confirm that any registered nurse can perform the nursing assessment, based on the Nurse Practice Act. Finally, public comment suggested that the term "nonroutine hospitalization" be removed from regulation, as this term is subjective and without a definition or explanation.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following questions:

Question h. Can the term “nonroutine hospitalization” be clarified, or is there any other term that should be used?

Question i. Should other nursing assessments be permitted as an alternative to the Resident Assessment Tool?

Question j. If other tools are used, what if any effect(s) will there be on the quality and consistency of important care decisions, such as the need for awake overnight staff?

- **Proposal #25:** *Reduce from weekly to monthly the required resident care note (COMAR 10.07.14.27).*

Current regulations require assisted living facilities to write resident care notes upon admission, and maintain these care notes on a weekly basis and/or when significant changes in the resident’s condition occur. Public comment suggested that the weekly requirement be altered to be a monthly requirement.

DRAFT RESPONSE: The Task Force declines this proposal. Weekly care notes are the appropriate minimal requirement in the assisted living environment, where observations by direct care staff regarding a resident’s status and any change of condition are relied on by clinicians who may only visit periodically.

Emergency Preparedness

- **Proposal #26:** *Waive the requirement that the resident’s emergency medical face sheet be reviewed monthly (COMAR 10.07.14.46C).*

Current regulations require that assisted living facilities develop an emergency and disaster preparedness plans that includes procedures that shall be followed before, during, and after an emergency or disaster. Regulations require that these plans guide the evacuation, transportation, or shelter in-place of residents, and describe how the facility will notify families and staff regarding the actions that will be taken to maintain the safety and well-being of residents. When residents must be re-located in these circumstances, regulations require the facility to send a brief medical face sheet with each resident that includes, at minimum, the following: name of resident; medical condition or diagnosis; medications; allergies; special diets or dietary restrictions; and family or legal representative contact information. Regulations require facilities to update the resident emergency medical face sheets if the condition of the resident changes and be reviewed at least monthly. Public comment suggested that the requirement that emergency medical face sheets be reviewed on a monthly basis be waived, as this requirement results in diverting staff away from providing direct patient care.

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Task Force supports changing the reviews from monthly to quarterly.

SECTION C: Adult Medical Day Care Facilities

Adult medical day care programs provide community-based services that meet the needs of functionally and/or cognitively impaired adults through an individualized plan of care. Adult medical day care centers operate for the purpose of providing medical day care services in an ambulatory care setting to medically compromised adults who do not require 24-hour inpatient care, but, due to their degree of impairment, are not capable of full-time independent living.

There are 123 licensed adult medical day care programs in Maryland, which have the capacity to serve approximately 7,000 adults. These programs may operate in leased properties, churches, multi-purpose centers, in or near nursing homes. These structured and comprehensive programs provide health care oriented services such as rehabilitation services and physical therapy, occupational and speech therapy and medical consultation services; assistance with activities of daily living; and counseling and nutritional services for the elderly and for adults with a medical disability who require at least one day of care per week in a day care program. Services are designed and tailored to meet the needs of participants during the day in a protective setting, while allowing individuals to continue living with their families or in the community.

Adult medical day care programs are regulated by the Office of Health Care Quality to promote the safety and well-being of the individuals receiving services and to ensure that these programs meet and maintain state licensure standards. Regulations are enforced through unannounced on-site surveys, follow-up visits, and complaint investigations

The Task Force received three proposals in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

Quality Assurance

- **Proposal #27: Remove the requirement that quality assurance plans include health care audit and utilization reviews (COMAR 10.09.07.03N and O).**

Current regulations require adult medical day care programs to have quality assurance programs, which include, at a minimum the following items: health care audits and utilization reviews that include a review of medical records for all participants; development and review of outcome criteria to identify problem areas or reasons for inadequate care; documentation of submission of recommended corrective action to the program director if inadequate care is provided; and reassessment of the appropriateness of the corrective action plan as revealed by the outcomes of the next audit. The regulations also require that the programs have a signed

and dated corrective action plan transferring the participant to an appropriate service if it is determined the program is not appropriate for the participant. Public comment indicated that health care audits and utilization review are already conducted by Delmarva, are not appropriate for inclusion in a quality assurance plan, and should not be required in regulation.

DRAFT RESPONSE: The Task Force declines this proposal. A provider is in the best position to review the quality and utilization of its own services; moreover, such review is a federal requirement for payment for services. In addition to extrinsic review of utilization by the Department and its contractors, the Department is also required under federal law to provide for methods to safeguard against unnecessary utilization of care and services and to assure that payments are consistent with efficiency, economy, and quality of care. The Centers for Medicare and Medicaid Services' approval of medical day care services under a home and community-based services waiver is contingent upon extensive quality assurance requirements and is subject to a federal audit. The Department's regulation accomplishes this by ensuring that providers who seek reimbursement for services track the appropriateness and utilization of services and monitor and improve the quality of services.

Reporting Requirements

- **Proposal #28: *Remove the requirement that programs maintain separate transportation records (COMAR 10.09.07.03L and 10.12.04.26D(1)(d)).***

Current regulations require providers to maintain daily transportation records for both the program and for each individual patient. COMAR 10.09.07.03L requires programs to have "accurate daily transportation records that are easily retrievable and available for review by the Program, and shall include, as a minimum, each participant's transportation plan." In addition, COMAR 10.12.04.26D(1)(d) also requires the programs to maintain "travel directions" if transportation services are provided, as part of the individual patient's records. Public comment suggested that the requirement to maintain "accurate daily transportation records" and "travel directions" is vague and unclear and should be amended and clarified. Public comment further indicated that some providers have received citations because records did not have driving directions to and from each participant's house to the center, which fails to acknowledge that directions are based on routes, not each participant's personal directions.

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Task Force supports the removal of the requirement of "travel directions," but will maintain and clarify the requirements of 10.09.07.03L, to more clearly require records reflecting compliance with other existing transportation requirements. These requirements include assurances that participants are dropped off with appropriate supervision, and that participants in transit for more than one hour have the opportunity for a rest stop.

Staffing

- **Proposal #29: *Remove the requirement that adult medical day care centers have a medical director (COMAR 10.09.07.04).***

Regulations require that adult medical day care programs have adequate staffing capability to monitor participants at all times. The centers are required to have a full-time, part-time, or contractual medical director who may also function as the physician for those participants who do not have a personal physician. Public comment suggested that the requirement of having a full-time, part-time, or contractual medical director be waived, as the types of programs are not residential programs, and participants already have personal physicians.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following questions:

Question k. Would the removal of the medical director requirement have an adverse impact upon participant care and safety?

Question l. How often do centers call upon the medical director for assistance with participant care?

SECTION D: Mental Health

Maryland's public mental health system is designed to promote consumer choice and facilitate access to services regardless of the ability to pay or health insurance status. An estimated 116,948 consumers utilized these services in Maryland in 2010, which are provided in a variety of settings, including residential programs, such as therapeutic group homes for youth and adults and residential rehabilitation programs, and community-based programs, such as mobile treatment services and psychiatric day treatment services. The goal of the state's regulation of mental health programs is to ensure that consumers receive quality mental health services and that programs meet the treatment needs of individual consumers. The Department of Health & Mental Hygiene works to ensure that a comprehensive system of mental health services and supports are available and accessible for children and adults, through their entire life-span. The Department provides statewide planning, design, development, implementation, administration, and monitoring of community-based mental health programs and services for children, adults, transition-age youth, and older adults. The Department develops policy, protocols, regulations and practice guidelines to encourage improved consumer outcomes and to promote evidence-based, consumer-directed and recovery-oriented rehabilitation, treatment and support programs that have demonstrated effectiveness and are responsive to consumer needs and preferences.

There are more than 1,500 licensed community mental health programs in the state, and services are provided by the following types of programs: Adult Group Homes with Mental Illness, Mental Health Vocational Programs, Mobile Treatment Services, Outpatient Mental Health Center, Psychiatric Rehabilitation Programs, Psychiatric Rehabilitation Services for Minors, Psychiatric Day Treatment Services, Residential Rehabilitation Programs, Residential Crisis Services, Respite Care Services, Therapeutic Group Homes and Therapeutic Nursery Programs. Community mental health programs are regulated by State and local agencies including the Office of Health Care Quality, to promote the safety and well-being of the individuals receiving services; to ensure that programs achieve performance standards and meet the individual needs of consumers; and to ensure that these programs meet and maintain state licensure and federal Medicare/Medicaid standards.

Regulations of community mental health programs are enforced through announced and unannounced on-site surveys and follow-up visits. DHMH collaborates with the Governor's Office for Children, as well as the Department of Human Resources and Department of Juvenile Services, as these child-serving agencies are involved in the placement of children in residential therapeutic group homes that are licensed and regulated by DHMH.

The Task Force received a total of 34 proposals in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

Therapeutic group homes

- ***Proposal #30: Eliminate the requirement that therapeutic group homes collaborate with local Core Service Agencies (COMAR 10.21.07.07).***

Current regulations require the operator of a therapeutic group home to collaborate with its local Core Service Agency, and to provide evidence of this collaboration to the Department as a condition of its licensure. In addition, as a condition of licensure, the therapeutic group home must provide documentation of the need for the therapeutic group home in the jurisdiction, provided in the form a letter of support from the Core Service Agency. It was suggested that this need for collaboration with the Core Service Agency be eliminated.

DRAFT RESPONSE: The Task Force declines this proposal. Collaboration between the therapeutic group home and the local Core Service Agencies is key to ensuring the group home continues to meet the needs of the local jurisdiction.

- ***Proposal #31: Eliminate the requirement that therapeutic group homes send discharge letters to local Core Service Agencies (COMAR 10.21.07.12F(2)).***

Current regulations require therapeutic group homes to collaborate with Core Service Agencies during the licensing and treatment periods. In addition, regulations require therapeutic group homes to notify the Core Service Agencies and Department when a child is discharged from the program. Public comment suggested that the requirement that Core Service Agencies be notified at the time of discharge be waived, citing instances when several Core Service Agencies directors returned the notification provided by the group home, indicating uncertainty as to why they (the Core Service Agencies) are receiving this information.

DRAFT RESPONSE: The Task Force supports with modification. The Task Force agrees that the role of the Core Service Agencies in receiving notification should be clarified, and is requesting additional public input on the following question:

Question m. Under what circumstances should therapeutic group homes notify Core Service Agencies about any or all discharges?

- ***Proposal #32: Update older versions of regulatory standards required of therapeutic group homes (COMAR 10.21.07) to reflect new standards (COMAR 14.31.05 and 14.31.06).***

Public comment indicated that some regulations pertaining to therapeutic group homes (COMAR 10.21.07) have not been updated or amended in more than 20 years, and that older regulations should be adjusted or eliminated, and replaced with new standards contained in newer regulation (COMAR 10.31.05 and 10.31.06).

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #33:** *Permit therapeutic group homes to serve nine children rather than the current limit of eight (COMAR 10.21.07.08).*

Current regulations place a cap on the number of children that a therapeutic group home can serve, to no more than eight children. Public comment suggested that this cap be raised to nine, consistent with the 1:3 staffing ratio (one staff for every three children) set forth in 10.21.07.13. This could enable homes to serve more children without increasing staff costs.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following question:

Question n. In the context of overall goals to serve individuals in smaller residential settings, will increasing the number of children who live in a therapeutic group home from eight to nine impact the quality of services children receive?

- **Proposal #34:** *Eliminate the requirement that a child must demonstrate sufficient cognitive ability in order to be admitted to a therapeutic group home (COMAR 10.21.07.09A(2)(c)).*

Current regulations set forth a number of eligibility criteria for children to be admitted to a therapeutic group home, including the following: (1) child must have a mental disorder; (2) child is or should be receiving treatment for mental disorder; (3) child requires residential services not available at home; (4) child requires 24-hour supervision in a structured private home; and (5) child has the ability to understand, and states, in writing, a willingness to comply with the rules and regulations of the therapeutic group home. Regulations prohibit therapeutic group homes from admitting children with a primary diagnosis of alcoholism or drug addiction; children who show current violent or antisocial behavior; and children who have “cognitive deficits that severely limit the child’s ability to benefit” from the treatment services provided. Public comment suggested that the requirement of sufficient cognitive ability be waived, or that more flexibility in admissions policies be provided to therapeutic group homes. It was indicated that many youth because of their psychiatric disabilities and/or learning disabilities do not score well on standardized IQ tests. It is proposed that regulations enable individual group home programs to use their best judgment as to whether an applicant for admission has the cognitive ability to benefit from the program.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following questions:

Question o. Is there a way to provide more flexibility for the admission of children who do not perform well on standardized tests but who do not have a true developmental disability?

Question p. What is the appropriate way to assess whether a child has the appropriate cognitive ability to benefit from a therapeutic group home setting?

- **Proposal #35:** *Extend the period of time for an initial assessment of the child (COMAR 10.21.07.11).*

Current regulations require that every child who is admitted to a therapeutic group home must be evaluated by the clinical coordinator. Regulations require that this evaluation must include a face-to-face assessment by the clinic coordinator, description of the presenting problem, relevant history, mental status examination, and the rationale for the diagnosis. In addition, the clinical coordinator is required to assure completion of an assessment for each child, before or within one week of admission to the therapeutic group home. Regulations require that this assessment include: (1) developmental history; (2) education history; (3) family history and evaluation of current family status; (4) home environment; (5) social, emotional, cognitive development; (6) motor, language, self-care skills; (7) history, if any, of substance abuse, physical or sexual abuse, or home/community violence; (8) involvement with the local Department of Social Services or Juvenile Services, if any; (9) mental status; and (10) medical history and needs. Public comment indicated that one week does not allow the clinical coordinator to complete a detailed initial assessment that provides information on each of these 10 items. It was proposed that the deadline for completion of the initial assessment be extended from 10 days to 30 days.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following question:

Question q: Which, if any, of the listed elements of the initial assessment (.11C) could be waived or included in subsequent assessments?

- **Proposal #36:** *Eliminate the requirement that therapeutic group homes collaborate with child's primary care physician (COMAR 10.21.07.11E).*

Current regulations require therapeutic group homes to develop an individual treatment plan within 30 days of the child's admission. Regulations require that plan reflect collaboration among the child, treatment team, primary caretaker, and that the plan is coordinated with the child's individualized education plan, when applicable, and with the child's medical care provider. It was suggested that requiring the individual treatment plan to reflect collaboration with the child's medical care provider is 'redundant,' and should be removed from regulation.

DRAFT RESPONSE: The Task Force declines this proposal. The child's primary care provider may have information and input on health that is critically important to the well-being of the child. The Task Force is seeking additional public input on the following question:

Question r. Are there specific approaches to coordination with the child’s primary care provider and therapeutic group homes that could be administratively more simple?

- **Proposal #37:** *Adjust the requirement that therapeutic group homes invite the participation and consent of family members when developing and implementing the child’s individualized treatment plan (COMAR 10.21.07.11.4(c)).*

Current regulations require therapeutic group homes to develop an initial individualized treatment plan for each child, and to invite, as appropriate and with proper consent, the participation of family members and community-based providers of services to the child. Thirty days after admission, the therapeutic group home is required to prepare an individualized treatment plan that will be addressed by the group home staff, in collaboration with the child, treatment team, primary caretaker and, as appropriate, family members. Public comment suggested that it is difficult to involve a family member or guardian in the child’s treatment if they have no desire to do so. Public comment proposed that therapeutic group homes be required to obtain parental/guardian signatures regarding the individualized treatment plan, and that the homes be required to provide evidence documenting efforts made to obtain this signature.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #38:** *Eliminate the requirement that therapeutic group homes develop initial individualized treatment plans and instead focus on the development and implementation of the child’s individualized treatment plan (COMAR 10.21.07.11.D).*

Current regulations require therapeutic group homes to develop an *initial* individualized treatment plan for each child within one week of admission. Public comment suggested that for a provider to develop a detailed, accurate treatment plan, the treatment team must observe the child in their environment and have a better understanding of their current symptoms and behaviors. Public comment suggested that these observations take longer than the seven days allotted to write the initial individualized treatment plan, and in fact would benefit from a full month of observation at the therapeutic group home. Public comment suggested that the requirement for the initial individualized treatment be removed from regulation.

DRAFT RESPONSE: The Task Force is seeking additional public input on the following questions:

Question s. What specific criteria for the initial individual treatment plans could be removed?

Question t. If the Department waived the requirement for the initial individualized treatment plans to be completed within one week, how could the Department ensure that the therapeutic group home has a plan to care for the child on day one of admission until an initial individualized treatment plan is developed?

- **Proposal #39:** *Eliminate the requirement that therapeutic group home staff record the child’s progress every two weeks (COMAR 10.21.07.11.F).*

Current regulations require that therapeutic group homes evaluate the progress of each child towards reaching the treatment goals outlined in the child's individualized treatment plan. Regulations require that all staff involved in contact with the child record all significant clinically relevant face-to-face, telephone, and written contacts with or about the child, and update these progress notes every two weeks. Public comment suggested that updating these progress notes every two weeks is onerous, and be removed from regulation.

DRAFT RESPONSE: The Task Force declines this proposal. Recording the child's progress on a regular and frequent basis is an important requirement. The Task Force is seeking additional public input on the following questions:

Question u. Are there specific elements in the required progress note (.11F) that may be simplified or that need not be updated every two weeks?

Question v. What is the appropriate level of regulatory oversight to assure that a case coordinator regularly assesses the child's response to services provided by a therapeutic group home?

- **Proposal #40:** *Add the term “Program Administrator” in regulation (COMAR 10.21.07.02).*

Current regulations recognize the following types of staff functions in mental health programs: (1) *Case Coordinator*, which is a mental health professional or residential care specialist who is supervised by a mental health professional who coordinates the services provided to a child, as outlined in a child's individual treatment plan; and (2) *Clinical Coordinator*, which is a mental health professional who is responsible for the oversight of the clinical services provided to children in a therapeutic group home. Public comment suggested that another staff function be added to regulation, “*Program Administrator*,” who is designated by the governing board of the therapeutic group home as having day-to-day responsibility for the overall administration and operation of the program and for assuring the care, treatment, safety, and protection of the children. It was proposed that the Program Administrator would have similar responsibilities to the role of Chief Executive Officer, and as such, regulations should interpret the Program Administrator as being “interchangeable” with the CEO. Adoption of this proposal would result in adjusting COMAR 10.21.07.10, 10.21.07.12, and 10.21.07.14.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #41:** *Recognize that psychiatric nurse practitioners perform many duties similar to psychiatrists (COMAR 10.21.07.02B(10)(A)).*

Current regulations define a “mental health professional” as a psychiatrist or “an individual who is authorized by the Health Occupations Article... to provide the service for which the individual is privileged.” Public comment indicated that many organizations are now working with psychiatric nurse practitioners (CRNP-PMH) in all types of clinical settings and

suggested that regulations be amended to recognize this growing role of psychiatric nurse practitioners.

DRAFT RESPONSE: The Task Force is seeking additional public input on the following questions:

Question w. What services could a psychiatric nurse practitioner provide in a therapeutic group home setting, consistent with his or her scope of practice?

Question x. Are there any limitations for a psychiatric nurse practitioner's role in this setting?

- **Proposal #42:** *Add the term “placement agency” to the list of entities recognized as primary caretakers (COMAR#10.21.07.02B(10)(A)).*

Current regulations define “primary caretakers” as the child’s custodial parent or parents, or an adult with whom the child currently resides. Public comment proposed that placement agencies be added to this definition of primary caretakers, indicating that many youth are committed to the Department of Social Services and the placement worker at the DSS should be viewed in regulation as a “primary caretaker.”

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Task Force supports amending the regulation to include “legal guardian.”

- **Proposal #43:** *Replace the term “Case Coordinator” with the term “Program Coordinator” (COMAR 10.21.07.02B(2)).*

Current regulations recognize a “Case Coordinator”, which is a mental health professional or residential care specialist who is supervised by a mental health professional who coordinates the services provided to a child, as outlined in a child’s individual treatment plan. Public comment suggested that the term “Case Coordinator” be replaced with the term “Program Coordinator,” as the term case coordinator does not imply the supervisory role required to assume the duties assigned to this critical function. It was proposed that the term program coordinator is a more descriptive title for carrying out the required responsibilities, and would require amending COMAR 10.21.07.11, 10.21.07.12, and 10.21.07.14.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #44:** *Clarify that the ultimate responsibility for identifying staff training needs and providing inservice training rests with the Chief Executive Officer, and the CEO should not be required to collaborate with the clinical coordinator and program staff in order to fulfill these responsibilities (COMAR 10.21.07.14B(3)(g)).*

Current regulations require a number of duties and responsibilities for the Chief Executive Officer of a therapeutic group home, including the following: providing administrative oversight; ensuring regulatory compliance; maintaining sufficient staff; and assuring the availability, 24 hours per day, 7 days per week, of a therapeutic group home psychiatrist. In

addition, regulations require the Chief Executive Office, *in collaboration with the clinical coordinator and program staff*, to identify staff training needs and the provision of in service training, to assure a minimum level of staff competence in understanding mental disorders and treatment modalities; use of seclusion, restraint, and quiet room; use of de-escalation techniques; and emergency preparedness and evacuation plans. Public comment suggested that the role of clinical coordinator is not a managerial role, and they are in no position to supervise or monitor staff, which is the role of a program coordinator. Public comment suggested that regulations be amended to reflect the CEO will collaborate with the program coordinator, not clinical coordinator, in areas relating to staff training and maintaining staff competence.

DRAFT RESPONSE: The Task Force declines this proposal. Collaboration with clinical staff is appropriate in determining staff training needs in a therapeutic group home.

- **Proposal #45:** *Clarify that ensuring staff compliance with credentialing and privileging are the responsibilities of the Chief Executive Officer, and as such, the CEO should not be required to collaborate with the clinical coordinator on these issues (COMAR 10.21.07.14.B(3)(e)).*

Current regulations require the Chief Executive Officer to assure staff compliance with credentialing and privileging, *in collaboration with the clinical coordinator*. Public comment suggested that the role of a clinical coordinator is not a management position, and has no role in supervising staff. Public comment suggested that the phrase, “in collaboration with the clinical coordinator” be removed from regulation, to clarify that it is the sole responsibility of the CEO to assure the credentialing and privileging of staff.

DRAFT RESPONSE: The Task Force supports this proposal.

- **Proposal #46:** *Clarify that the responsibility for ensuring appropriate supervision of staff rests with the Chief Executive Officer, not Clinical Coordinator (COMAR 10.21.07.14.B(3)(f)).*

Current regulations require the Chief Executive Officer to ensure appropriate supervision of staff, *in collaboration, when appropriate, with the clinical coordinator*. Public comment suggested that the role of a clinical coordinator is not a management position, and has no role in supervising staff. It was proposed that the phrase, “in collaboration, when appropriate, with the clinical coordinator” be removed from regulation, to clarify that it is the sole responsibility of the CEO to assure the appropriate supervision of staff.

DRAFT RESPONSE: The Task Force declines this proposal. The requirement is collaboration, when appropriate, and not direct management or supervision by clinical staff.

- **Proposal #47:** *Remove the requirement that clinical coordinators be responsible for establishing protocols for medical and psychiatric emergencies (COMAR 10.21.07.14.C(3)(e)).*

Current regulations require a clinical coordinator, if the clinical coordinator does not also serve as the Chief Executive Officer, to be responsible for establishing protocols for medical and psychiatric emergencies and crisis response plans. It was proposed that this function is the responsibility of the CEO and not the clinical coordinator.

DRAFT RESPONSE: The Task Force declines this proposal.

- **Proposal #48:** *Clarify that responsibility for maintenance of the therapeutic milieu is the responsibility of the program coordinator, not of clinical coordinator (COMAR 10.21.07.14C(3)(g)).*

Current regulations require the clinical coordinator to be responsible for maintenance of the “therapeutic milieu” to facilitate continued quality of care for children receiving services at the therapeutic group home. It was suggested that this is a management responsibility, which should be the responsibility of the program coordinator, not clinical coordinator.

DRAFT RESPONSE: The Task Force supports this proposal with modification. A licensed mental health professional must be responsible for maintaining the therapeutic milieu of the group home. If neither the program coordinator nor CEO is a licensed mental health professional, then this responsibility must be executed by the clinical coordinator, who is a mental health professional.

- **Proposal #49:** *Waive the requirement that a psychiatrist participate in the screening, assessment, admission, and discharge process (COMAR 10.21.07.14D(3)(a)).*

Current regulations require that a psychiatrist participate in the screening, admission, and discharge processes at therapeutic group homes. It was proposed that the requirement that a psychiatrist’s participation be removed from regulation, and instead, language be added that the psychiatrist be consulted when necessary, but not required to participate.

DRAFT RESPONSE: The Task Force declines this proposal. Therapeutic group homes offer intensive mental health services, usually involving medication. It is appropriate for a psychiatrist to be involved in processes relating to the administration of medication to children in these settings. The Task Force is seeking additional public comment on the following questions:

Question y. What circumstances, if any, do not require a psychiatrist to participate in the screening, admission, and discharge processes at therapeutic group homes?

Community Mental Health Programs

- **Proposal #50:** *Streamline the application process for community mental health programs (COMAR 10.21.16).*

Current regulations require that applicants for community mental health programs submit an application to the Department and the Core Service Agency where the services will be provided. In cases where the program will serve multiple jurisdictions, the Department will determine the lead Core Service Agency. It was proposed that entities should be able to submit a single application to operate multiple sites, rather than having to submit an individual application for each site.

DRAFT RESPONSE: The Task Force supports this proposal with modification. Providers must continue disclose in the application process the specific services being provided at each site, as well as ownership and leadership of each provider type at each site. However, the Department will explore whether this could be accomplished with a single application for multiple sites.

- **Proposal #51: *Allow community mental health programs to use one Medicaid number for multiple sites. (COMAR 10.21.16).***

Current regulations require that community mental health programs obtain separate Medicaid numbers for each service delivery site. It was proposed that having a separate Medicaid number, for each site, complicates the billing system, and requested the ability to have one Medicaid number for multiple sites.

DRAFT RESPONSE: The Task Force declines the proposal. The assignment of individual Medicaid numbers for each site enables the Department to monitor utilization and need for services. Moreover, sites are licensed and equipped to provide different services and there are varying payments according to provider types for services rendered.

- **Proposal #52: *Streamline the licensing review process by utilizing ten critical indicators to evaluate the overall health, safety, and well-being of service recipients (COMAR 10.21.17.03).***

Approval of a license to operate a community mental health program requires the program to meet regulatory standards for a community mental health program (COMAR 10.21.17) and the standards for an outpatient clinic (COMAR 10.21.20). Public comment suggested that having to meet two separate sets of standards is onerous, and suggested that the regulations for approval of licensure of community mental health programs be based on ten critical indicators that would be used to evaluate the overall health, safety, well-being, and recovery of service recipients. Public comment further indicated that the Office of Health Care Quality's reviews of community programs are focused on a strict interpretation of individual regulations without regard for the relative importance of each regulation and the regulation's impact on the overall quality of the consumer's life, the overall quality of the service, and the actual real-life outcomes of the service.

DRAFT RESPONSE: The Task Force is seeking additional public input on the following question:

Question z. If the Department were to substitute “critical indicators” for a full review of regulatory standards as a requirement of licensure, how would the Department select the indicators best measuring quality of services?

- **Proposal #53:** *Streamline regulatory compliance visits conducted by multiple divisions of the Department (COMAR 10.16.21.11).*

Current regulations enable the Department, Core Service Agency, and Administrative Services Organization to conduct announced and unannounced visits of community mental health programs. Public comment indicated that some programs are visited multiple times by different divisions of the Department (such as the Office of Health Care Quality and the Mental Hygiene Administration), and each visit has a different set of quality review standards, which results in a huge drain on staff resources and on direct service provision. It was proposed that the Department, Core Service Agencies, and the Administrative Services Organization unify quality review standards into a single consistent body of requirements and consolidate site visits into one on-site visit per year per provider.

DRAFT RESPONSE. The Task Force supports this proposal with modification. Reviewers may have different purposes, for example, one reviewer’s purpose may be to focus on appropriate utilization of services and another, the quality of those services. Additionally, when there are concerns about a provider, it may be appropriate for there to be multiple reviews. The Department will review current numbers of visits and purposes of visits of reviewing agencies to determine whether there is duplication. The Department will report on this review on or before December 1, 2011.

- **Proposal #54:** *Streamline the eligibility determinations for non-Medicaid consumers of the public mental health system (COMAR 10.21.17.03).*

Current regulations require community mental health providers to collect information from non-Medicaid consumers to assess the individual’s ability to pay for services, including any information about access to health insurance benefits, in an attempt to determine eligibility for services in the public mental health system. It was proposed that the State streamline the eligibility determination process for the public mental health system, and require the state’s Administrative Service Organization, Value Options, to be responsible for eligibility determinations, not individual providers.

DRAFT RESPONSE: The Task Force declines this proposal. Maintaining access to timely and accurate eligibility determinations and reimbursement claims data is integral to the integrity of the system. Providers have unique access to information on individual patients. Reviewing organizations are not in the same position to follow up with individual patients. These issues were raised recently in a Department of Legislative Services audit of the Mental Hygiene Administration.

- **Proposal #55:** *Adjust regulations that require community mental health providers to inform consumers about mental health advance directives (COMAR 10.21.17.04).*

Current regulations require community mental health providers to inform consumers about advance directives for mental health services. The regulations require the provider to document whether the consumer has a mental health advance directive, provide a copy of the directive in the consumer's file (if the consumer has one), and provide assistance to the consumer if he/she does not have an advance directive and requests information. It was proposed that the regulation be amended to require the program to state to a consumer that an advance directive may be useful and refer the consumer to an approved source of information.

DRAFT RESPONSE: The Task Force declines this proposal.

Mobile Treatment Services

- **Proposal #56: *Eliminate the requirement that a mental health professional serve as program director of community programs such as Mobile Treatment Teams, Assertive Community Treatment Teams, and Psychiatric Rehabilitation Programs (COMAR 10.21.19.08, 10.21.20.10, 10.21.21.10B, and 10.21.29.09G).***

Current regulations require the program director of community programs such as Mobile Treatment Teams, Assertive Community Treatment Teams, and Psychiatric Rehabilitation Programs to be a mental health professional. Public comment proposed that instead of the requirement that a program director be a mental health professional, that the program director “have sufficient qualifications, knowledge, and experience to execute the duties of the position.”

DRAFT RESPONSE: The Task Force is seeking additional public input on the following questions.

Question aa. If the credential of a mental health professional is not required, what criteria would the program and the Department use to evaluate whether an individual has the requisite “qualifications, knowledge and experience” to serve as program director of a mental health program?

- **Proposal #57: *Eliminate or adjust required staffing ratios for mobile treatment services (COMAR 10.21.19.11, 10.21.21.12, 10.21.26.09, 10.21.28.12, and 10.21.29.09).***

Current regulations require mobile treatment service providers to maintain a staffing ratio of 1:12, namely one full-time treatment staff person for each 12 persons served. In calculating the average staffing ratio, regulations do not allow the provider to include the program director, consultants, or volunteers. Public comment suggested that budget reductions and poor reimbursement rates for community mental health providers have exacerbated a deepening workforce crisis. Public comment further indicated that turnover rates for direct care positions exceed 30% on average and vacancy rates in all clinical areas are approaching a 15% average. It was proposed that regulatory staffing ratios be eliminated, and replaced with language directing the program to maintain staffing levels “to be sufficient to carry out the goals and objectives of the program.” Public comment indicated that if eliminating staffing

ratios are not acceptable, then the ratio for child psychiatric rehabilitation programs should be changed from 1:6 to 1:8 (COMAR 10.21.29H).

DRAFT RESPONSE: The Task Force is seeking additional public input on the following questions:

Question bb. What are objective measures (other than staffing ratios) that demonstrate a mobile treatment program is providing sufficient services?

Question cc. How do other states measure or ensure that appropriate staffing levels are provided in mobile treatment settings?

Outpatient Mental Health Clinics

- ***Proposal #58: Eliminate the requirement that staff of outpatient mental health clinics be required to sign each progress note (COMAR 10.21.20.07B(1)(i), 10.21.21.06D(1)(a)(vi), and 10.21.29.06D(10)(a)(vi)).***

Current regulations require that staff of outpatient mental health clinics sign each progress note documenting the progress of consumers. Public comment suggested that this is an onerous regulation, and particularly problematic for outpatient clinics, whose clinicians barely have time to perform their primary function of treatment. It was proposed that this requirement for signature of progress notes be waived, or amended to allow electronic signatures.

DRAFT RESPONSE: The Task Force supports this proposal to permit electronic signatures.

- ***Proposal #59: Eliminate the multi-site staffing requirements of outpatient mental health clinics (COMAR 10.21.20.11).***

Current regulations require that outpatient mental health clinics that operating multiple sites meet and maintain required staffing ratios and that the program director and medical director provide on-site consultation at each site, to ensure adequate clinical and administrative oversight. It was proposed that these multi-site staffing requirements be waived, or adjusted such that the number of specific hours for a clinician to be on-site be relaxed. Public comment acknowledged the Department's interest in ensuring that each outpatient mental health clinic site is comprehensive and capable of full service delivery, but indicated that these staffing requirements are too costly and onerous to maintain. It was proposed that providers be required to document the availability of appropriate staffing from anywhere within the agency, ie. that the agency can make appropriate staff coverage available, without requiring each site to meet the specified requirements.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following questions:

Question dd. Is there an alternative to requiring staffing information at each site that will assure appropriate full service delivery without overburdening the outpatient mental health providers?

Question ee. How will the Department establish objective criteria to evaluate documentation provided by the outpatient mental health providers indicating that staff on other sites are “available,” such as reviewing patient volume at sites, miles between sites?

Psychiatric Rehabilitation Programs

- ***Proposal #60: Eliminate the requirement that a licensed mental health professional must refer consumers to psychiatric rehabilitation programs as a condition of consumer eligibility (COMAR 10.21.21.05 and 10.21.29.05).***

Current regulations require, as a condition of consumer eligibility for psychiatric rehabilitation programs, that the consumer be referred to these programs by a licensed mental health professional. This referral is forwarded to the Administrative Services Organization, which in turn pre-authorizes the consumer for treatment. Public comment indicated that having to obtain a signed referral from a mental health professional is a significant administrative burden on these programs. It was proposed that the calculation of medical necessity should be conducted by the Administrative Services Organization, not by the licensed mental health professional or provider.

DRAFT RESPONSE: The Task Force declines this suggestion. Referral from a mental health professional to psychiatric rehabilitation programs is critical for care coordination. In addition, the Department must be able to document care coordination as a part of federal waiver requirements.

- ***Proposal #61: Adjust authorization periods for Medicaid-eligible and uninsured psychiatric rehabilitation program recipients (COMAR 10.21.21.06(C)(3)).***

Current regulations require that psychiatric rehabilitation program service providers review and record progress toward the accomplishment of previously identified rehabilitation goals in the individual’s record, and update this record every six months, at minimum. Public comment has suggested the following two adjustments to the authorization periods for psychiatric rehabilitation program services: (1) Require 1-year authorization periods and treatment plan review periods for Medicaid-eligible psychiatric rehabilitation program recipients, instead of every six months; and (2) Require six-month authorization periods for uninsured psychiatric rehabilitation program recipients, instead of every three months. In addition, public comment suggested the authorization role of the Core Service Agency and Administrative Services Organization be streamlined. The commenter indicated that the development of a new Individual Rehabilitation Plan every six months for Medicaid-eligible consumers and every three months for uninsured consumers creates a massive administrative

challenge for providers and the Administrative Services Organization. Rather than having to re-do the entire Individual Rehabilitation Plan every six months, it was proposed that a streamlined “update form” could be used to document continued need for psychiatric rehabilitation programs services.

DRAFT RESPONSE: The Task Force declines this proposal. This proposal is in conflict with federal Centers for Medicare and Medicaid Services requirements. The implementation of health reform will require the Department to be able to continue to demonstrate aggressive review of psychiatric rehabilitation program services to ensure that active treatment services are being provided, that medical necessity review criteria are being met, and the services being provided are needed by the consumer.

- **Proposal #62:** *Eliminate the requirement that psychiatric rehabilitation programs must have a 24/7 emergency response plan in place for children and adolescents when the psychiatric rehabilitation program is not open (COMAR 10.21.29.07E(1)).*

Current regulations require psychiatric rehabilitation programs that are serving children and adolescents to have on-call and emergency response services available by a licensed mental health professional face-to-face when the psychiatric rehabilitation program is open, and to have a 24/7 emergency response plan available, by telephone, on an on-call basis, when the program is not open. It was proposed that the requirement for the 24/7 emergency response plan when the psychiatric rehabilitation program is not open be waived.

DRAFT RESPONSE: The Task Force declines this proposal. Regulations simply require the provider to have a 24/7 emergency response plan in place for when the psychiatric rehabilitation program is not open, not be open 24/7. This plan, which may simply be a referral to another source of services, is necessary for adequate after hours clinical care while decreasing unnecessary reliance upon hospital emergency rooms.

- **Proposal #63:** *Eliminate the requirement that psychiatric rehabilitation program direct care staff must have 60 hours of on-the-job direct psychiatric rehabilitation program supervision before providing services to minors served by the program without supervision (COMAR 10.21.29.09G(2)(b)).*

Current regulations require that direct care staff working in a psychiatric rehabilitation program must have at least 60 hours of direct, psychiatric rehabilitation program supervision before providing psychiatric rehabilitation program services to minors without supervision. Public comment suggested that this requirement be waived, and the providers be allowed to exercise professional judgment in determining when a staff person is capable of delivering direct services.

DRAFT RESPONSE: The Task Force declines this proposal. Providers should be responsible for ensuring that direct care staff are credentialed, receive appropriate training and orientation, and receive appropriate supervision before providing direct care psychiatric rehabilitation program services.

SECTION E: Developmental Disabilities

The Department provides a coordinated service delivery system for people with developmental disabilities to support appropriate services, oriented toward the goal of self directed supports in community settings. More than 22,500 people access these services each month, which are provided through a combination of state residential centers (providing services to individuals with a developmental disability) and a wide array of community based services which are delivered primarily through a network of non-profit providers.

Currently, Maryland's Developmental Disabilities Administration licenses more than 200 community based providers operating more than 2,600 individual sites. Community providers include community residential services, community supported living arrangements, family support services, individual support services, resource coordination, and vocational and day habilitation services, including supportive employment. The Office of Health Care Quality, as an agent of the Developmental Disabilities Administration, licenses and regulates these programs, using state regulations that set forth minimum standards for provision of care, and conducts surveys to determine compliance. When problems or deficiencies are noted, the Office of Health Care Quality initiates administrative action against facilities that violate State rules and regulations. If an agency fails to correct problems and is unable or unwilling to do so, the Office of Health Care Quality may impose sanctions such as license revocation, fines, bans on admission, or other restrictions on the operating license.

The Task Force received six proposals in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

Licensing and Services Delivery

- ***Proposal #64: Update licensing regulations to distinguish between programs that provide services to adults with developmental disabilities and children with developmental disabilities (COMAR 10.22.02.01).***

Current regulations provide licensing standards for community based programs that provide services to people with developmental disabilities. These licensing standards pertain to programs serving both adults and children with developmental disabilities. Public comment suggested that these regulatory licensing standards could be updated, to distinguish between programs serving adults versus programs serving children. In addition, public comment indicated that the licensing standards in this section of COMAR may be geared more towards programs serving adults. Public comment suggested that the core regulations promulgated by the Governor's Office for Children be the exclusive source of regulations for children's group homes serving children with developmental disabilities, and that additional provisions specific to developmental disabilities in this regulatory section (COMAR 10.22.02.01) not apply.

DRAFT RESPONSE: The Task Force is requesting additional public input on the following question:

Question ff. Which specific requirements in COMAR 10.22.02.01 should not be applicable to programs serving children with developmental disabilities?

- ***Proposal #65: Adjust the regulatory requirement when Individual Plans are updated, from annually to at least every three years (COMAR 10.22.05.03).***

Current regulations (COMAR 10.22.05.03C(2)) require that Individual Plans be updated on an annual basis, and that individuals participate in a meeting to update the Individual Plans once a year. Public comment suggested that individuals may not need to participate in an annual meeting, and that regulations be amended to require that the planning meeting occur “at least every three years,” but not on an annual basis. In addition, public comment suggested that regulations should indicate that an update of the Individual Plans be triggered by a major life event change in the individual.

DRAFT RESPONSE: The Task Force supports this proposal with modification. Recently proposed federal regulations to the Home and Community Based Services Waiver require each Individualized Plan to include individual timelines for review. Comments to the proposed regulations emphasized the need to tailor an individual plan to meet the needs of the individual. These regulations are not final, but should the new regulations take effect, this language would support the change from an annual requirement to requiring a timeline for review, based upon the individual's needs, not to exceed two years. Of course any Individual Plan should be reviewed upon request of the consumer. The Centers for Medicare and Medicaid Services would need to approve a change in Maryland regulations as to the frequency of plan review.

- ***Proposal #66: Clarify the Developmental Disabilities Administration provider payment system regulations by replacing the term “prospective payment system” with “fee payment system” (COMAR#10.22.17.02(B)(15)).***

Current regulations regarding the Developmental Disabilities Administration provider payment structure define a “fee payment system” as the “system for rate setting and reimbursement for services provided by licensed residential, day habilitation, vocational, and supported employment programs.” The regulations later define “funding level” as “the total annual amount of money awarded by the Administration under the *prospective payment system* or under a contract for a day habilitation, vocational, or residential program.” Public comment suggested that the term “prospective payment system” be replaced with “fee payment system,” as this term is used in COMAR earlier.

DRAFT RESPONSE: The Task Force supports this proposal.

- ***Proposal #67: Remove the requirement that providers complete annual wage and benefits surveys and require these every three years (COMAR 10.22.18.03(A)(4)(c)).***

Current regulations require community supported living arrangement providers, as a condition of reimbursement by the Department, to submit an annual cost report to the Department, and this cost report is required to include an annual wage and benefits survey. Public comment suggested that the completion of an annual wage and benefits survey is burdensome, and requested this requirement be relaxed to every three years.

DRAFT RESPONSE: The Task Force supports this request with modification. The Task Force would initially support a relaxation of the wage and benefit survey requirement to every two years. It should be noted that wage survey data is used to calculate provider rates.

Record Retention

- ***Proposal #68: Update regulations to facilitate providers to maintain records electronically and update these records on a quarterly basis (COMAR 10.22.02.13).***

Current regulations require providers to maintain records for each individual receiving services, which should document the individual's emergency contact, physician, current diagnosis, potential allergies, and list of current medications. Public comment suggested that regulations be updated to allow providers to maintain electronic copies of these records and reports.

DRAFT RESPONSE: The Task Force supports this proposal.

- ***Proposal #69: Waive requirements to maintain individual records for five years and instead update these records on a quarterly basis (COMAR 10.22.02.13)***

Current regulations require providers to maintain records for each individual receiving services, which should document the individual's emergency contact, physician, current diagnosis, potential allergies, and list of current medications. Providers are required to maintain these records for a minimum of five years, and make records and reports available for inspection by the Department upon request. Public comment suggested that the five-year requirement be waived, and regulations be amended to enable providers to update the records on a quarterly basis.

DRAFT RESPONSE: The Task Force declines this proposal. Maryland law requires a 5-year retention of medical records, and the Centers for Medicare and Medicaid Services has similar records retention requirements for waiver funded services. As to review and update of these records, the Task Force is seeking additional public input on the following question:

Question gg. Which record entries and reviews may be limited to a quarterly basis and which must be more frequent for developmental disabilities providers?

SECTION F: Substance Abuse Treatment Programs

The goal of substance abuse treatment programs is to facilitate access to effective, evidence-based substance use treatment services, regardless of ability to pay or health insurance status, and help individuals on their path to recovery. Approximately 21,000 Marylanders access substance use treatment programs each month, and types of programs include opioid maintenance therapy programs, outpatient treatment programs, residential programs, early intervention, detoxification treatment, and education programs.

Organizations that provide substance and alcohol use treatment services must maintain certifications for each program-level of service that they provide. Program-level certifications must be renewed every two years. There are more than 1,000 certified substance abuse treatment programs in Maryland, which must meet state and federal guidelines, in accordance with the guidelines established by the American Society of Addiction Medicine Patient Placement Criteria. Substance use treatment programs are certified and regulated by the Office of Health Care Quality, which enforces certification requirements through surveys, announced and unannounced site visits, and complaint investigations. The goal of this regulation is to ensure that state resources are supporting effective treatment programs and that certified programs meet and maintain state and federal standards.

The Task Force received four public proposals in this area.

Please note that proposals to be implemented by the Department must also go through the formal regulatory process, including formal public comment, before taking effect.

- **Proposal #70: Create unique service regulations for co-occurring treatment programs in outpatient setting (COMAR 10.47.02.04).**

Current regulations require treatment programs to have a detailed description of eligibility criteria, which are based on guidelines such as the American Society of Addiction Medicine Patient Placement Criteria. Patients must meet the admission criteria of these guidelines in order to participate in the treatment programs. The programs are required to prepare a comprehensive assessment for each patient, unless the patient is being readmitted to the same program or admitted to a different program within 30 days of the patient's last discharge. Regulations require that the assessment include the following factors: (1) physical health; (2) employment or financial support; (3) drug or alcohol; (4) treatment history; (5) legal; (6) family and social; (7) educational; and (8) mental health. Treatment programs are required to use the Addiction Severity Index as the standardized assessment instrument for adults and the Problem Oriented Screening Instrument for teenagers. Programs are required to develop a written treatment plan, with the participation of the patient, which is based on the comprehensive assessment and patient placement criteria, and reflects the following patient individualized needs: (1) socialization; (2) alcohol and drug abuse or dependence; (3) psychological; (4) vocational; (5) educational; (6) physical health; (7) legal; and (8) family.

Regulations indicated that the length of stay in the program shall be based on the patient's level of illness severity and response to treatment.

Level I outpatient treatment programs are required to provide outpatient evaluation and treatment to adult patients less than 9 hours weekly and less than 6 hours weekly for adolescent patients. Alcohol and drug counselors in these programs are not permitted to exceed 30 adult patients per week or 25 adolescent patients per week.

Public comment suggested that regulations be amended to create a separate or unique set of regulations for co-occurring treatment programs, which reflect the unique treatment needs of patients receiving mental health and substance use treatment services. Public comment indicated that co-occurring treatment regimens do not follow the same regimen of substance use only treatment programs, and as such, should have a different set of regulatory criteria governing length of stay, frequency of treatment, and patient-to-client ratios. Public comment indicated that clinicians should be able to have greater freedom around appropriate services, length of stay, and frequency of visits.

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Department is reviewing its regulations for mental health and substance use treatment in a separate process to better reflect co-occurring treatment needs. These comments will be incorporated into this review.

- **Proposal #71:** *Amend the time frames for completion of certain clinical tasks (COMAR 10.47.02.04).*

Current regulations require that treatment programs must schedule an initial interview date within 10 working days of the individual's initial contact. Regulations also require treatment plans to have completed an individualized treatment plan within 7 working days of the comprehensive assessment and updated every 90 days. Public comment suggested that the 10-day requirement for completion of the comprehensive assessment be changed to be required at the time of the second visit. Public comment also suggested that the requirement that treatment plans be developed within 7 days of the assessment be changed to be required at the time of the fourth visit. Public comment questioned the rationale of current regulatory time frames and indicated that these time frames "create a rush to get things done instead of recognizing the needs of individuals to get well and/or facility to do the best job possible." In addition, public comment suggested that the 90-day required review of treatment plans be waived and that regulation "needs to recognize the intent."

DRAFT RESPONSE: The Task Force is requesting additional public input on the following questions:

Question hh. What are the appropriate time frames for the completion of an initial assessment and an individual treatment plan?

Question ii. How frequently should treatment plans be reviewed and updated by substance abuse treatment providers?

Question jj. If the 90-day required review of treatment plans is relaxed or waived, how should the Department ensure that plans are reviewed and updated to timely adapt to patients' changing needs?

- **Proposal #72:** *Require providers to report discharge information in SMART (COMAR 10.47.01.04).*

Current regulations require programs to prepare a written discharge summary, which includes the reason for admission; reason for discharge; individual's address; summary of services delivered; diagnosis and prognosis (if appropriate); current medications, if applicable; continuing service recommendations and a summary of the transition process; and the extent of the individual's involvement in the discharge plan. The discharge summary is required to be completed within 30 days of the individual's discharge from the program. Public comment suggested that regulations be amended to require the same information as the State of Maryland Automated Record Tracking (SMART) system.

DRAFT RESPONSE: The Task Force supports this proposal to have the required information be consistent.

- **Proposal #73:** *Require that treatment plans in opioid maintenance therapy be updated only every 180 days after the first year, rather than every 90 days as is required (COMAR 10.47.02.11).*

Current regulations require that individualized treatment plans be updated at least once every 90 days. Public comment suggested that opioid maintenance therapy programs are long-term programs, and as such, should be required to update patient's treatment plans only every 180 days after the patient has completed one year of the program. Public comment further indicated that as the acute phase of treatment winds down (one or two years into the program), successful clients will focus more on recovery and less on treatment, and that updating treatment plans every 90 days is "unnecessary" and "tedious in this phase of recovery."

DRAFT RESPONSE: The Task Force supports this proposal with modification. The Task Force supports amending the 90-day update regulation for individualized treatment plans for clients who are stable and progressing through treatment. However, for patients who are not stable, the 90-day review is appropriate.

APPENDIX A: List of Regulatory Proposals and Draft Response

Proposal #	COMAR Citation	Summary of Proposal	Name of Organization submitting proposals	Draft Assessment of Public Proposals			
				Support	Support w modification	Requires Further Study	Decline
Long Term Care - TWENTY-ONE (21) PROPOSALS							
1	10.07.02.01 B	Update Maryland's regulatory definitions to reflect the national implementation of new person-centered standard care assessments.	HFAM	X			
2	10.07.02.37	Allow resident discretion regarding the notification of family members in care planning conferences.	HFAM	X			
3	10.07.02.12 G	Amend regulation so that the requirements on the role of the Director of Nursing position become guidelines.	HFAM				X
4	10.07.02.15	Clarification that nursing facilities may use "Leave of Absence Policies" for medications.	HFAM	X			
5	10.07.02.15 C (1) (o)	Return of unused medications at nursing homes.	HFAM	X			
6	10.07.02.03-1	Enable nursing homes to increase bed capacity in times of an emergency without getting prior approval from the Department.	HFAM				X
7	10.07.02.08 G	Reduce notification requirements for admission of patients with communicable diseases at nursing homes.	HFAM		X		
8	10.07.02.23	Combine patient transport and resident relocation policies for nursing homes into a single regulation.	HFAM				X
9	10.07.02.25	Waive DHMH approval for construction of new nursing facilities.	HFAM	X			
10	10.07.02.26 F (5) (c)	Waive the requirement that nursing homes must have at least 48 hours worth of emergency power stored on-site.	HFAM				X
11	10.07.02.28 C (1)	Modify requirements regarding the distance between beds at nursing homes.	HFAM			X	
12	10.07.02.29 B	Simplify requirements for hot water bottles and ice at nursing homes.	HFAM		X		
13	10.07.02.31	Remove size specifications for dining areas and dayrooms at nursing homes.	HFAM				X
14	10.07.02.32	Enable nursing homes to make changes to existing kitchens and dietetic service areas without having to secure an advance waiver from DHMH.	HFAM				X
15	10.07.02.10 C (4) and H (2)	Update all of 10.07.02 to reflect the usage of electronic health records and electronic signatures.	HFAM	X			
16	10.07.02.20	This regulation requires nursing home to maintain proper patient records and should be amended to reference the use of electronic health records.	HFAM	X			
17	10.07.02.27	Add regulatory language that would permit the use of wireless call bell systems that are pager activated versus audible and amend language that mandates that a call station includes detachable extension cord to each patient's bed.	HFAM	X			
18	10.07.02.27	Facilitate resident self-administration of medications at nursing homes.	HFAM		X		

Proposal #	COMAR Citation	Summary of Proposal	Name of Organization submitting proposals	Draft Assessment of Public Proposals			
				Support	Support w modification	Requires Further Study	Decline
19	10.07.02.28 B (10)	Enable opposite-sex siblings to share the same room at nursing homes.	HFAM	X			
20	10.07.02.28 D	Amend regulation so that personal furnishings are allowable under the patient and/or family's choice.	HFAM			X	
21	10.07.02.13	Update regulation to be more accommodating to various dining styles as well as person centered care in regards to the frequency, quality and timing of meals.	HFAM	X			
Assisted Living- FIVE (5) PROPOSALS				Support	Support w modification	Requires Further Study	Decline
22	10.07.14.19	Recommends that regulation that requires first aid for other staff be done on an initial and annual training should be amended to make it "on an initial ongoing basis" similar to CPR.	LifeSpan Network		X		
23	10.07.14.19	Remove regulations that require staff submit a physicians statement to prove that the employee is free from certain "impairments".	LifeSpan Network	X			
24	10.07.14.26B	Update service plan requirements of assisted living providers to reflect Nurse Practice Act.	LifeSpan Network			X	
25	10.07.14.27D	Reduce from weekly to monthly the required resident care note at assisted living facilities.	LifeSpan Network				X
26	10.07.14.46C(4)	Waive the requirement at assisted living facilities that the resident's emergency medical face sheet be reviewed monthly.	LifeSpan Network		X		
Adult Medical Day Care - THREE (3) PROPOSALS				Support	Support w modification	Requires Further Study	Decline
27	10.09.07.03N and O	Remove the requirement that quality assurance plans at adult medical day care facilities include health care audit and utilization reviews.	LifeSpan Network				X
28	10.09.07.03L and 10.12.04.26D(d)	Remove the requirement that adult medical day care programs maintain separate transportation records.	LifeSpan Network		X		
29	10.09.07.04B(2)	Remove the requirement that the medical adult day care center have a full-time, part-time or contractual medical director.	LifeSpan Network			X	
Mental Health - THIRTY-FOUR (34) COMMENTS				Support	Support w modification	Requires Further Study	Decline
30	10.21.07.07	Eliminate the requirement that therapeutic group homes collaborate with local Core Service Agencies.	MARFY				X
31	10.21.07.12.F(2)	Eliminate the requirement that therapeutic group homes send discharge letters to local Core Service Agencies.	Mosaic Community Services		X		
32	10.21.07	Update older versions of regulatory standards required of therapeutic group homes (COMAR 10.21.07) to reflect new standards.	MARFY	X			
33	10.21.07.08	Permit therapeutic group homes to serve nine children rather than the current limit of eight.	MARFY			X	
34	10.21.07.09 A (2) (c)	Eliminate the requirement that a child must demonstrate sufficient cognitive ability in order to be admitted to a therapeutic group home.	GUIDE Program, Inc.			X	
35	10.21.07.11. C	Extend the period of time for an initial assessment of the child at therapeutic group homes.	Mosaic Community Services			X	
36	10.21.07.11.2(E)	Eliminate the requirement that therapeutic group homes collaborate with child's primary care physician.	Mosaic Community Services				X

Proposal #	COMAR Citation	Summary of Proposal	Name of Organization submitting proposals	Draft Assessment of Public Proposals			
				Support	Support w modification	Requires Further Study	Decline
37	10.21.07.11.4(c)	Adjust the requirement that therapeutic group homes invite the participation and consent of family members when developing and implementing the child's individualized treatment plan.	Mosaic Community Services	X			
38	10.21.07.11.D	Eliminate the requirement that therapeutic group homes develop initial individualized treatment plans and instead focus on the development and implementation of the child's individualized treatment plan.	Mosaic Community Services			X	
39	10.21.07.11.F(2)	Eliminate the requirement that therapeutic group home staff record the child's progress every two week.	Mosaic Community Services				X
40	10.21.07.02	Add the term "Program Administrator" in regulation for therapeutic group homes.	Mosaic Community Services	X			
41	10.21.07.02. B(10)(a)	Recognize that psychiatric nurse practitioners perform many duties similar to psychiatrists at therapeutic group homes.	Mosaic Community Services			X	
42	10.21.07.02. B(10)(a)	Add the term "Placement agency" to the list of entities recognized as primary caretakers by therapeutic group homes.	Mosaic Community Services		X		
43	10.21.07.02.B(2)	Replace the term "Case Coordinator" with "Program Coordinator" .	Mosaic Community Services	X			
44	10.21.07.14. B(3)(g)	Clarify that the ultimate responsibility for identifying staff training needs and providing inservice training rests at therapeutic group homes. with the Chief Executive Officer, and the CEO should be not be required to collaborate with the clinical coordinator and program staff in order to fulfill these responsibilities.	Mosaic Community Services				X
45	10.21.07.14.B(3)(e)	Clarify that ensuring staff compliance with credentialing and privileging are the responsibilities of the Chief Executive Officer at therapeutic group homes, and as such, the CEO should not be required to collaborate with the clinical coordinator on these issues.	Mosaic Community Services	X			
46	10.21.07.14.B(3)(f)	Clarify that the responsibility for ensuring appropriate supervision of staff of therapeutic group homes, rests with the Chief Executive Officer, not Clinical Coordinator.	Mosaic Community Services				X
47	10.21.07.14.C(3)(e)	Remove the requirement that clinical coordinators be responsible for establishing protocols for medical and psychiatric emergencies at therapeutic group homes.	Mosaic Community Services				X
48	10.21.07.14.C(3)(g)	Clarify that responsibility for maintenance of the therapeutic milieu is the responsibility of the program coordinator, not of clinical coordinator at therapeutic group homes.	Mosaic Community Services		X		
49	10.21.07.14.D(3)(a)	Remove from regulation the requirement that a psychiatrist participate in the screening, assessment, admission, and discharge process.	Mosaic Community Services				X
50	10.21.16	Allow community mental health facilities to submit one application to operate multiple sites, rather than individual applications for each site.	Community Behavioral Health Association of MD		X		
51	10.21.16	Allow community mental health programs to use one Medicaid number for multiple sites.	Community Behavioral Health Association of MD				X
52	10.21.16.03	Update regulations to streamline the licensing review process, to include 10 critical indicators or areas that are judged to affect the overall health, safety, well-being and recovery of service recipients.	Community Behavioral Health Association of MD			X	
53	10.21.16.11	Streamline regulatory compliance visits conducted of mental health programs by multiple divisions of the Department.	Community Behavioral Health Association of MD		X		
54	10.21.17.03	Streamline the eligibility determinations for non-Medicaid consumers of the public mental health system.	Community Behavioral Health Association of MD				X

Proposal #	COMAR Citation	Summary of Proposal	Name of Organization submitting proposals	Draft Assessment of Public Proposals			
				Support	Support w modification	Requires Further Study	Decline
55	10.21.17.04C	Adjust regulations that require community mental health providers to assist consumers with mental health advanced directives.	Community Behavioral Health Association of MD				X
56	10.21.19.08; 10.21.20.10; 10.21.21.10B; 10.21.29.09G(1)(a)	Eliminate the requirement that a mental health professional serve as program director of community programs such as Mobile Treatment Teams, Assertive Community Treatment Teams, and Psychiatric Rehabilitation Programs.	Community Behavioral Health Association of MD			X	
57	10.21.19.11; 10.21.21.12 (see more below)	Eliminate or update required staffing ratios for mobile treatment services.	Community Behavioral Health Association of MD			X	
58	10.21.20.07B(1)(i); (see below)	Waive the requirement that staff at outpatient mental health clinics must sign their name to each progress note or amend to allow for electronic signatures.	Community Behavioral Health Association of MD	X			
59	10.21.20.11	Eliminate multi-site staffing requirements for outpatient mental health clinics. At a minimum, remove requirements for a) persons of two separate licensures to be on-site for multi-site clinics and b) a specified number of hours for clinicians to be on-site.	Community Behavioral Health Association of MD			X	
60	10.21.21.05, 10.21.29.05	Eliminate the requirement for a mental health professional referral to Psychiatric Rehabilitation Program services as a condition of consumer eligibility.	Community Behavioral Health Association of MD				X
61	10.21.21.06 (C)(3)	Update regulations to extend authorization periods for Medicaid eligible and uninsured psychiatric rehabilitation program recipients.	Community Behavioral Health Association of MD				X
62	10.21.29.07E(1)	Eliminate the 24/7 emergency response for child and adolescent Psychiatric Rehabilitation Program when not open.	Community Behavioral Health Association of MD				X
63	10.21.29.09G(2)(b)	Eliminate the requirement that psychiatric rehabilitation program direct care staff must have 60 hours of on-the-job direct psychiatric rehabilitation program supervision before providing services to minors served by the program without supervision.	Community Behavioral Health Association of MD				X
Developmental Disabilities - SIX (6) COMMENTS				Support	Support w modification	Requires Further Study	Decline
64	10.22.02.01	Update licensing regulations to distinguish between programs that provide services to adults with developmental disabilities and children with developmental disabilities.	MARFY			X	
65	10.22.05.03	Adjust regulations on the frequency of updating Individual Plans, from annually to every three years.	eMerge, Inc.		X		
66	10.22.17.02(B)(15)	Clarify the Developmental Disabilities Administration provider payment system regulations by replacing the term "prospective payment system" with "fee payment system".	MD Association of Community Services	X			
67	10.22.18.03(A)(4)(c)	Remove the requirement that providers complete annual wage and benefits surveys and require these every three years	MD Association of Community Services		X		
68	10.22.02.03 C 10.22.02.13(A)	Update regulations to allow developmental disabilities providers to maintain electronic copies of required records.	MD Association of Community Services	X			
69	10.22.02.13	Waive requirements of developmental disabilities providers to maintain individual records for five years.	The Arc Northern Chesapeake Region				X
Substance Abuse - FOUR (4) PROPOSALS				Support	Support w modification	Requires Further Study	Decline
70	10.47.01.04	Create unique service regulations for co-occurring treatment programs in outpatient setting.	Mosaic Community Services		X		
71	10.47.02.04	Amend the time frames for completion of certain clinical tasks at substance abuse treatment programs.	Mosaic Community Services			X	
72	10.47.02.04	Require substance abuse treatment programs providers to report discharge information in SMART.	Mosaic Community Services	X			
73	10.47.02.11	Require that treatment plans in opioid maintenance therapy be updated only every 180 days after the first year, rather than every 90 days as is required.	Glenwood Life Counseling Center		X		

APPENDIX B: List of Questions Requiring Further Information

Proposal #	COMAR Citation	Questions for Additional Public Comment
Long Term Care - SEVEN (7) Questions		
8	10.07.02.23	Question a. What amendments, if any, should be made to regulations governing resident transport and relocation to make the requirements more efficient and effective, while preserving resident security and safety?
11	10.07.02.28 C (1)	Question b. What, if any, barriers or practical difficulties might prevent a resident's bed from being placed against a wall.
11	10.07.02.28 C (1)	Question c. To the extent there are barriers or practical difficulties, do these exist for all residents or for residents with certain health care or mobility needs?
14	10.07.02.32	Question d. What, if any, specific requirements as to kitchens and food services should be subject to change by a facility during renovation without the Department's prior approval?
20	10.07.02.28 D	Question e. Are there reasonable limitations or requirements in permitting residents to bring in their own furnishings?
21	10.07.02.13	Question f. How should the Department review such requirements as frequency of meals, posting of menus, to better reflect current goals of person-centered care?
21	10.07.02.13	Question g. Which specific standards in COMAR 10.07.02.13((G) and (H) are appropriate for change?
Assisted Living- THREE (3) Questions		
24	10.07.14.26B	Question h. Can the term "nonroutine hospitalization" be clarified, or is there any other term that should be used?
24	10.07.14.26B	Question i. Should other nursing assessments be permitted as an alternative to the Resident Assessment Tool?
24	10.07.14.26B	Question j. If other tools are used, what if any effect(s) will there be on the quality and consistency of important care decisions, such as the need for awake overnight staff?
Adult Medical Day Care - TWO (2) Question		
29	10.09.07.04B(2)	Question k. Would the removal of the medical director requirement have an adverse impact upon participant care and safety?
29	10.09.07.04B(2)	Question l. How often do centers call upon the medical director for assistance with participant care?

Proposal #	COMAR Citation	Questions for Additional Public Comment
Mental Health - NINETEEN (19) Questions		
31	10.21.07.12.F(2)	Question m. Under what circumstances should therapeutic group homes notify Core Service Agencies about any or all discharges?
33	10.21.07.08	Question n. In the context of overall goals to serve individuals in smaller residential settings, will increasing the number of children who live in a therapeutic group home from eight to nine impact the quality of services children receive?
34	10.21.07.09 A (2) (c)	Question o. Is there a way to provide more flexibility for the admission of children who do not perform well on standardized tests but who do not have a true developmental disability?
34	10.21.07.09 A (2) (c)	Question p. What is the appropriate way to assess whether a child has the appropriate cognitive ability to benefit from a therapeutic group home setting?
35	10.21.07.11	Question q. Which, if any, of the listed elements of the initial assessment (.11C) could be waived or included in subsequent assessments?
36	10.21.07.11.2(E)	Question r. Are there specific approaches to coordination with the child's primary care provider and therapeutic group homes that could be administratively more simple?
38	10.21.07.11	Question s. What specific criteria for the initial individual treatment plans could be removed?
38	10.21.07.11	Question t. If the Department waived the requirement for the initial individualized treatment plan to be completed within one week, how could the Department ensure that initial individualized treatment plan are conducted and completed in a timely fashion?
39	10.21.07.11.F(2)	Question u. Are there specific elements in the required progress note (.11F) that may be simplified or that need not be updated every two weeks?
39	10.21.07.11.F(2)	Question v. What is the appropriate level of regulatory oversight to assure that a case coordinator regularly assesses the child's response to services provided by a therapeutic group home?
41	10.21.07.02. B(10)(a)	Question w. What services could a psychiatric nurse practitioner provide in a therapeutic group home setting, consistent with his or her scope of practice?
41	10.21.07.02. B(10)(a)	Question x. Are there any limitations for a psychiatric nurse practitioner's role in this setting?
49	10.21.07.14.D(3)(a)	Question y. What circumstances, if any, do not require a psychiatrist to participate in the screening, admission, and discharge processes at therapeutic group homes?
52	10.21.16.03	Question z. If the Department were to substitute "critical indicators" for a full review of regulatory standards as a requirement of licensure, how would the Department select the indicators best measuring quality of services?
56	10.21.19.08; 10.21.20.10; 10.21.21.10B; 10.21.29.09G(1)(a)	Question aa. If the credential of a mental health professional is not required, what criteria would the program and the Department use to evaluate whether an individual has the requisite "qualifications, knowledge and experience" to serve as program director of a mental health program?
57	10.21.19.11; 10.21.21.12	Question bb. What are objective measures (other than staffing ratios) that demonstrate a mobile treatment program is providing sufficient services?
57	10.21.19.11; 10.21.21.12	Question cc. How do other states measure or ensure that appropriate staffing levels are provided in mobile treatment settings?
59	10.21.20.11	Question dd. Is there an alternative to requiring staffing information at each site that will assure appropriate full service delivery without overburdening the outpatient mental health providers?
59	10.21.20.11	Question ee. How will the Department establish objective criteria to evaluate documentation provided by outpatient mental health providers indicating that staff on other sites are "available," such as reviewing patient volume at sites, miles between sites?

Proposal #	COMAR Citation	Questions for Additional Public Comment
Developmental Disabilities - TWO (2) Questions		
64	10.22	Question ff. Which specific requirements in COMAR 10.22.02.01 should not be applicable to programs serving children with developmental disabilities?
69	10.22.02.13	Question gg. Which record entries and reviews may be limited to a quarterly basis and which must be more frequent for developmental disabilities providers?
Substance Abuse - THREE (3) Questions		
71	10.47.02.04	Question hh. What are the appropriate time frames for the completion of an initial assessment and an individual treatment plans?
71	10.47.02.04	Question ii. How frequently should treatment plans be reviewed and updated by substance abuse treatment providers?
71	10.47.02.04	Question jj. If the 90-day required review of treatment plans is relaxed or waived, how should the Department ensure that plans are reviewed and updated to timely adapt to patients' changing needs?

APPENDIX C: Form for Additional Public Comment

Task Force on Regulatory Efficiency Comment Submission to Interim Report

DATE SUBMITTED

ORGANIZATION

CONTACT

Name

Title/Position

TELEPHONE & EMAIL

Telephone

Email

COMAR CITATION

PROPOSAL NUMBER

COMMENT ON DRAFT RESPONSE

QUESTION LETTER

QUESTION

RESPONSE TO QUESTION